Cappahard Lodge

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

CAPPAHARD LODGE

Cappahard Lodge, Tulla Road, Ennis

Date of Publication: 26th May 2023

ID Number: AC0167

2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing Mental Health Care / Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation

Conditions Attached:
Yes

Most Recent Registration Date:
1 October 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Nuala Kelly, General Manager, Mid West Mental Health Services

Inspection Team:
Megan Barry Sheehy, Lead Inspector
Raj Ramasawmy
Martin McMenamin

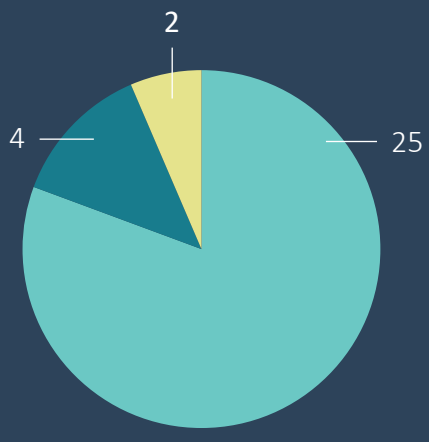
Inspection Date:
01 – 04 November 2022

Previous Inspection date:
23 – 26 March 2021

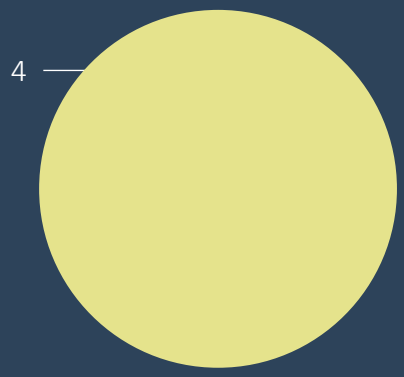
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Type:
Announced Annual Inspection

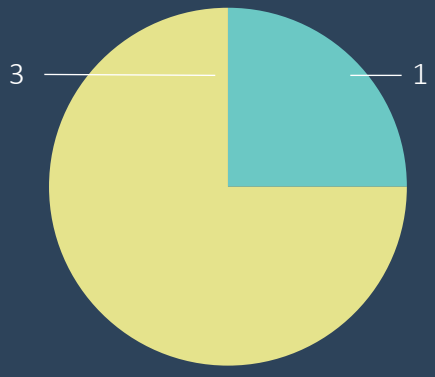
2022 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



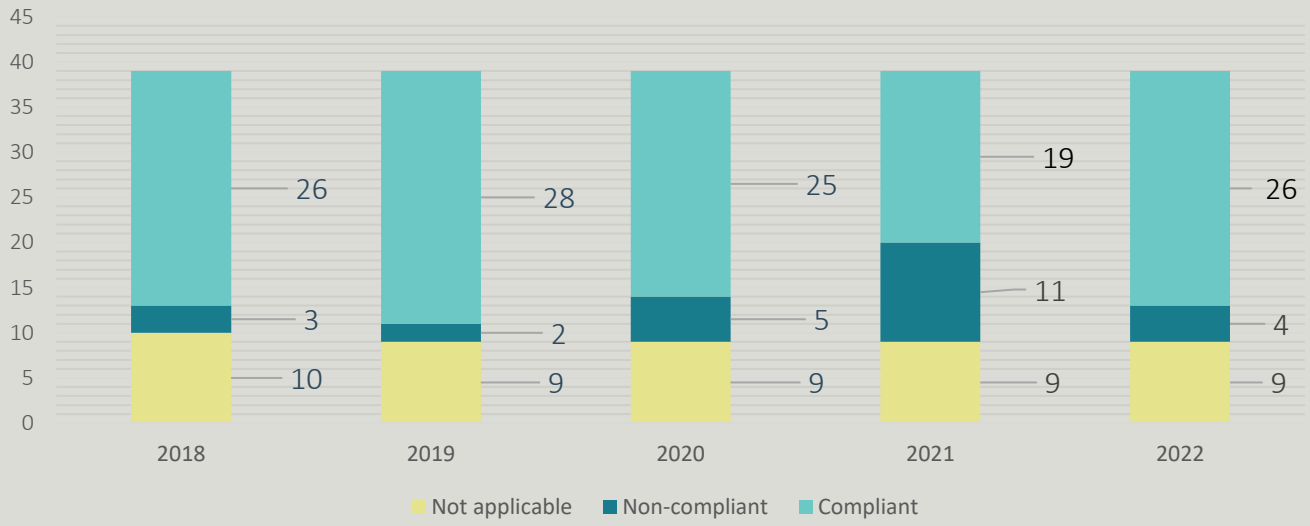
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2018 – 2022

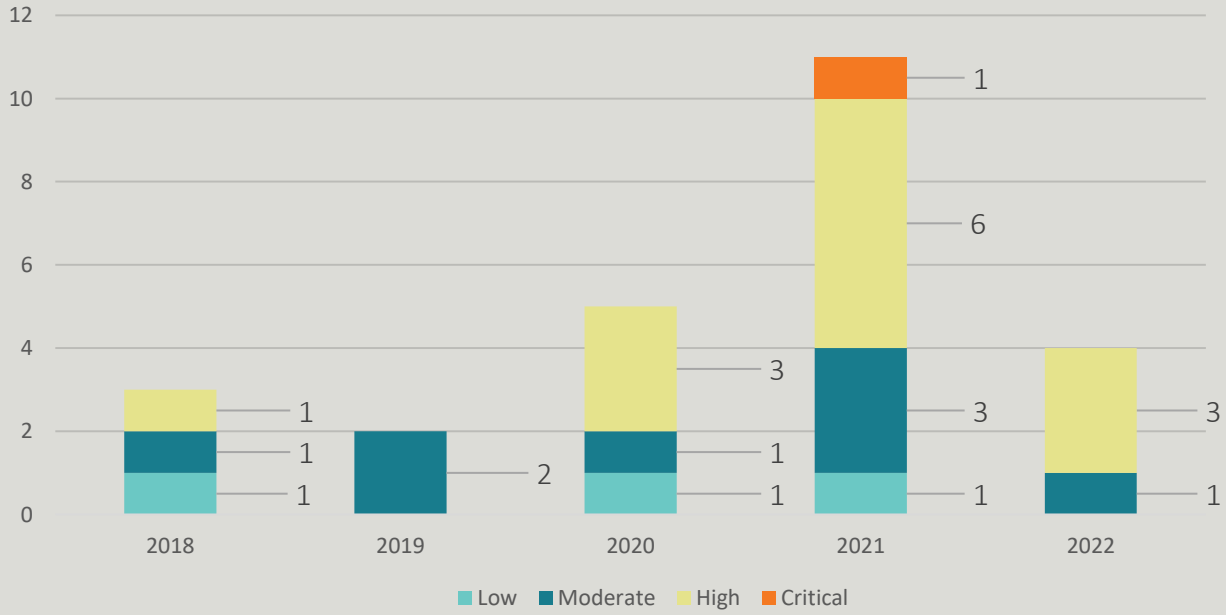
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2018 – 2022



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2018 – 2022



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. In line with Public Health Guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with Regulations, Rules and Codes of Practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

The approved centre was a bungalow on the outskirts of Ennis town, Co. Clare, built around an inner courtyard garden. There were five mental health teams admitting to the approved centre: Two Psychiatry of Old Age teams and three Rehabilitation and Recovery teams. Most residents were admitted and cared for by the Rehabilitation and Recovery teams.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	90%	93%	83%	63%	87%

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 26(4): Staffing the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*	The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	*31/03/2021*	*Critical risks identified in relation to therapeutic services and programmes*	*Further to the concerns identified on inspection, an Immediate Action Notice was issued in relation to Regulation 16: Therapeutic Services and Programmes. The notice required the Registered Proprietor to take urgent steps to address the concerns identified on inspection. The registered proprietor has submitted assurances and a comprehensive plan to address the concerns identified. The monitoring of these actions is ongoing.*

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	*17/11/2021*	*High risks identified in relation to staff training and risk of exposure to second-hand smoke.*	*Further to the Immediate Action Notice issued, the registered proprietor has submitted a plan to ensure that staff are fully trained by the date specified by the Mental Health Commission. The registered proprietor also submitted a costed, funded and timebound plan for the development of an external smoking area and the interim steps to mitigate the risk of second hand smoke in the approved centre. The Mental Health Commission continues to follow up on this matter with the registered proprietor.*

Safety in the approved centre

We found that the approved centre operated safe practices which reduced risk of harm to the residents and that effective systems were in place to safeguard patients in the following areas:

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks and risk of falls.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.

However:

- The frequency of administration of medication, including the minimum dose interval, for 'as required' (PRN) medication was not recorded in four of the five medication prescription and administration records inspected.
- Ligature anchor points were not reduced to the lowest practicable level.
- Not all healthcare staff were trained in Basic Life Support, Fire Safety, the Management of Violence and Aggression, and the Mental Health Act 2001.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities and physical health monitoring appropriate to the needs of residents in the following areas:

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- The approved centre provided an occupational therapy group and a psychology group by appointment, as well as nurse-lead groups and podiatry reviews.
- Group activities provided by the approved centre included a social work led group, art therapy, gardening group, walking group and a relaxation and mindfulness group.
- Physiotherapy and tissue viability assessments were accessed by referral from Ennis General Hospital. OT seating assessment needs were met by referral to the primary care OT. Speech and language therapy (SALT) was provided via a private SALT service. Dietetic services were accessed via primary care, and prescribed diets were reflected in residents' care plans.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index (BMI), weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents' privacy, dignity and autonomy

We found that facilities and processes respected residents' privacy and dignity and that interactions respected residents' wishes in the following areas:

- The approved centre had thirty-two single bedrooms. There were no en suites in the approved centre, however, there was access to eight communal toilet and shower facilities.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.
- The approved centre had been recently painted at the time of inspection. New flooring had been added to most of the main areas, and new furniture and curtains had also been purchased.

However:

- Some floor areas in the clinical room and office areas remained in need of replacement. Toilet and shower floors were stained and in one area tape had been used as a sealant as the flooring was torn. The new flooring outside the smoking area had cigarette burns in several areas. Patches of paint were required in areas where soap dispensers had been replaced.
- There were two smoking areas in the approved centre. On the day of inspection, cigarette smoke was visible and the smell of cigarettes was evident in the main corridor leading to the dining room. This internal smoking area was adjacent to resident bedrooms and on the same corridor as the dining rooms and sitting areas of the approved centre. This was a serious risk to both residents' and staffs' health.

Responsiveness to residents' needs

We found that the approved centre provided services in a way that met the needs of residents and their families.

- An activities co-ordinator was employed by the approved centre. Activities included a hair and beauty group, a music appreciation group, a crafts group, gardening groups, relaxation and mindfulness groups, newspaper reviews, mindfulness colouring, and walks.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialising.

Governance, Leadership and Accountability

- The approved centre was under the governance of the Mid-West Mental Health Service Management team which included counties Limerick, Clare and North Tipperary and which met monthly. The

governance of the approved centre was managed locally by the Clare and North Tipperary management team.

- The area lead attended the executive management meetings and the Quality and Safety Meeting and raised concerns or queries from residents, residents' family or resident's representatives.
- The Clare and North Tipperary management team held a Quality and Safety Meeting and a Risk Management Meeting monthly for the wider service. The assistant director of nursing for the approved centre attended both meetings and represented the needs of the approved centre.
- The approved centre had a local risk register and applicable risks had been escalated to the relevant forum if necessary. All incidents had been appropriately reported and the approved centre used the National Incident Management System (NIMs). The risk manager reviewed the incidents for patterns and trends.
- A representative from Peer Advocacy in Mental Health was available to the residents of the approved centre. Weekly resident's meetings took place in the approved centre. Minutes for these meetings indicated that activity planning and requests from residents were discussed frequently at these meetings.
- The process for making a complaint was publicly displayed and available to residents and family members. The details of the complaints officer were displayed and in an information booklet in each of the resident's bedroom. No formal complaints had been made since the previous inspection. Minor complaints were documented with clear actions and outcomes detailed.
- The area lead for mental health engagement provided resident, resident family, and representative engagement forums. These forums were based in the community and both residents and families could attend. Residents of the approved centre were able to meet individually with the area lead for mental health engagement.

However:

- Risks in relation to the internal smoking room were evident on the register but no steps had been highlighted on the risk register to remove the smoking room from the approved centre.
- The need for a call bell system to be installed in all bedrooms was also risk rated high by the approved centre. At the time of inspection, the call bell system had not been installed although funding had been approved.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. New blinds, curtains and floors had been installed, and the approved centre had been painted since the last inspection.
2. Wi-Fi had been installed in the approved centre for use by the residents.
3. A phone charger kiosk was installed in the approved centre.
4. New sensory equipment including sensory lights, sensory board and sensory tubes were purchased for the approved centre.
5. Anti-ligature wardrobes were installed in some bedrooms in the approved centre.
6. Staff were trained in venepuncture and wound management.
7. A multi-factorial falls risk assessment had been implemented for all residents.
8. A new infrared system had also been introduced that had significantly reduced risk of falls for residents within the centre.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located within the outskirts of Ennis town, Co. Clare. The premises was a bungalow built around an inner courtyard garden. A second enclosed garden was also available to the residents. The approved centre consisted of thirty-two single bedrooms. There were no en suites in the approved centre; however, there was access to eight communal toilet and shower facilities. An assisted bath was also available to residents. A foyer area with seating and a tea and coffee station was accessible at the entrance to the approved centre. Residents had access to a communal day room, therapy room and two dining rooms.

There were five mental health teams admitting to the approved centre: Two Psychiatry of Old Age teams and three Rehabilitation and Recovery teams. Most residents were admitted and cared for by the Rehabilitation and Recovery teams.

The resident profile on the first day of inspection was as follows:

Resident Profile	
Number of registered beds	***32***
Total number of residents	**18**
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	15
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under the governance of the Mid-West Mental Health Service Management team which included counties Limerick, Clare and North Tipperary. The governance of the approved centre was managed locally by the Clare and North Tipperary management team.

The Mid-West Mental Health Services Management Team comprised of the director of nursing, head of service, business manager, area lead for mental health engagement, and quality and safety risk advisor. This team met monthly, and discussions around the approved centre were evident in the meeting minutes.

The Clare and North Tipperary management team held a Quality and Safety Meeting and a Risk Management Meeting monthly for the wider service. The assistant director of nursing for the approved centre attended both these meetings and represented the needs of the approved centre. Agenda items included the risk register, capital needs and the ongoing quality improvement plans.

There was an organisational chart to identify the leadership and management structure and lines of authority and accountability within the approved centre. Each clinical discipline had its own governance structure, with clear line management processes in place. All heads of discipline identified strategic aims for their teams and discussed potential operational risks within their departments.

There were key personnel with responsibility for risk management working in the approved centre. The approved centre had a risk manager. The person with overall responsibility for risk was identified and known by staff. The approved centre had a local risk register and applicable risks had been escalated to the relevant forum if necessary. The risk register contained health and safety risks, clinical risks and corporate risks. All incidents had been appropriately reported and the approved centre used the National Incident Management System (NIMs). The risk manager reviewed the incidents for patterns and trends.

The risk register was a comprehensive document that was reviewed regularly. Risks in relation to the internal smoking room were evident on the register; however, no steps had been highlighted on the risk register to remove the smoking room from the approved centre. The need for a call bell system to be installed in all bedrooms was also risk rated high by the approved centre. At the time of inspection, the call bell system had not been installed, funding had been approved.

The approved centre was adequately staffed. Core staff included nursing staff, health care assistants, psychologist, social worker and an occupational therapist. Governance questionnaires were completed by the heads of discipline and returned to the inspection team. The inspector spoke with each head of discipline as part of the inspection process. Each head of discipline outlined clear strategic goals for the service and the systems that were in place to monitor goal attainment. Clinical supervision was provided for medical staff and the health and social care professional groups. There was a low level of compliance with mandatory staff training evident in the approved centre.

A representative from Peer Advocacy in Mental Health was available to the residents of the approved centre. The representative provided a combination of in person and virtual support to the residents. Weekly resident's meetings took place in the approved centre. This provided an opportunity for residents to raise concerns or make suggestions. A review of the minutes for these meetings indicated that activity planning and requests from residents were discussed frequently at these meetings.

The process for making a complaint was publicly displayed and available to residents and family members. The details of the complaints officer were displayed in communal areas throughout the approved centre and in an information booklet in each of the resident's bedroom. Formal complaints were dealt with by a complaints officer who was not based in the approved centre. No formal complaints had been made since the previous inspection. Minor complaints were documented with clear actions and outcomes detailed.

The area lead for mental health engagement provided resident and resident family and representative engagement forums. These forums were based in the community and both residents and families could attend. Residents of the approved center were able to meet individually with the area lead for mental health engagement. The area lead attended the executive management meetings and the Quality and Safety Meeting and raised concerns or queries from residents, residents' family or resident’s representatives.

3.3 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2018 and 2022 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2018		2019		2020		2021		2022	
Regulation 22: Premises	✗	High	✗	Moderate	✗	Moderate	✗	High	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✗	Low	✗	High	✗	Moderate
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	High	✗	Moderate	✗	High
Regulation 32: Risk Management Procedures	✓		✓		✓		✗	High	✗	High

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in **Appendix 1** of the report.

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.

Code of Practice on the Use of Physical Restraint in Approved Centres	As no resident in the approved centre had been physically restrained since the last inspection, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. The inspection team met with residents face-to-face as part of the inspection process.

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team face-to-face.
- The Peer Advocacy in Mental Health representative was contacted to obtain residents' feedback about the approved centre.

No resident completed a resident's questionnaire during the inspection process and no resident met with the inspection team for an interview. Family members and representatives of residents were offered the opportunity to complete a phone interview with the inspection. No family member or representative completed a phone interview with the inspection team.

5.2 Advocacy

The approved centre had a peer advocate attached whom the residents engaged with. The peer advocate engaged primarily with the residents in person. Phone support was also provided at the time of inspection. A report was received from the peer advocate as part of the inspection process. The report from the peer advocate included feedback from one resident only.

6.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Assistant Director of Nursing
- Area Director of Nursing
- Acting Registered Proprietor
- Clinical Director
- Clinical Nurse Manager 2
- Clinical Nurse Manager 1
- Consultant Psychiatrist Rehab Team
- Occupational Therapy Manager
- Principal Psychologist
- Principal Social Worker
- Risk Manager
- Senior Psychologist

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

7.0 Inspection Findings – Regulations

EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions

Regulation 4: Identification of Residents

COMPLIANT

The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers which were appropriate to the resident group profile and individual residents' needs. Photographs, date of birth and hospital record numbers were all utilised to identify residents.

Resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.

(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident's individual care plan.

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals and a source of safe, fresh drinking water was available at all times in the approved centre.

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

The approved centre provided suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements, and residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans. No resident was prescribed to wear nightclothes during the day at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents' personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in July 2020.

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Two safes in a locked room were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP or in accordance with the approved centre's policy.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. An activities co-ordinator was employed by the approved centre. Activities included a hair and beauty group, a music appreciation group, a crafts group, gardening groups, relaxation and mindfulness groups, newspaper reviews, mindfulness colouring, and walks.

The approved centre provided access to recreational activities on weekdays and during the weekend. Weekend activities included board games, card games, a movie day each Sunday, and a foods of the world event which was undertaken each month.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as is practicable. The approved centre had an oratory on-site, and Mass was available on television and in the day area.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident's individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in July 2022.

Visiting times were appropriate and reasonable. There were no visiting restrictions on any resident at the time of inspection. Appropriate steps were taken to ensure the safety of residents and visitors during visits. A separate visitors' room or visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting area was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

(1) Subject to subsections (2) and (3), the registered proprietor and the clinical director shall ensure that the resident is free to communicate at all times, having due regard to his or her wellbeing, safety and health.

(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and outgoing communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on communication.

(4) For the purposes of this regulation "communication" means the use of mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in May 2022.

Residents in the approved centre had access to mail, e-mail, Internet, telephone or any device for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health. Residents had access to Wi-Fi, and computer tablets were provided to access the internet. There were no restrictions on any resident's communication at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident's dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in July 2020, and included all requirements related to:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she is accommodated.
- The consent requirements of a resident regarding searches.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

As there had been no searches carried out since the last inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:

(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;

(b) in so far as practicable, his or her religious and cultural practices are respected;

(c) the resident's death is handled with dignity and propriety, and;

(d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

(a) in so far as practicable, his or her religious and cultural practices are respected;

(b) the resident's death is handled with dignity and propriety, and;

(c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. The policy was last reviewed in July 2022.

The clinical file of one resident who had died in the approved centre was examined on inspection. The end-of-life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs. The death was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident representatives, family, next of kin, and friends. All deaths of residents were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was complaint with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

The registered proprietor shall ensure that each resident has an individual care plan.

[Definition of an individual care plan:"... a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation".]

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Five ICPs were inspected. All ICPs were a composite set of documentation. Specific space and sections were allocated for needs, goals, treatment, care, resources required, and reviews.

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, and within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

ICPs identified goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to review by the MDT in consultation with the resident, weekly in an acute setting, and at least every six months for residents in a continuing care facility. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). The approved centre provided an occupational therapy group and a psychology group by appointment, as well as nurse-lead groups, podiatry reviews, and hairdresser and beauty therapy also.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. Group activities provided by the approved centre included a social work led group, art therapy, gardening group, walking group and a relaxation and mindfulness group.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Physiotherapy and tissue viability assessments were accessed by referral from Ennis General Hospital. Occupational therapy seating assessment needs were met by referral to the primary care OT. Speech and language therapy (SALT) was provided via a private SALT service. Dietetic services were accessed via primary care, and prescribed diets were reflected in residents' care plans.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in July 2020. The clinical file of one resident who had been transferred from the approved centre was inspected. As it was an emergency transfer, communications between the approved centre and the receiving facility were documented and followed up with a written referral. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

INSPECTION FINDINGS

The approved centre had a written policy on responding to medical emergencies. The policy was last reviewed in September 2020.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

Three clinical files were examined in relation to the provision of general health services during the inspection process. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, medication review, and body mass-index (BMI), weight, and waist circumference. For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation, blood lipids, prolactin (where required), and electrocardiogram (ECG) heart function.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes that were available according to age and gender, including the following: breast check; cervical screening; retina check (diabetics only); and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident's multi-disciplinary team;

(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;

(c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;

(d) details of relevant advocacy and voluntary agencies;

(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in January 2020.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support resident's needs.

The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets, and verbal information were provided in a format appropriate to resident needs. Medication information sheets included all relevant information on indications for use and any possible side-effects. Residents had access to interpretation and translation as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. Not all ligature points were minimised to the lowest practicable level, based on risk assessment, at the time of inspection.

The approved centre was not kept in good a state of repair internally. The approved centre had been recently painted at the time of inspection. New flooring had been added to most of the main areas, and new furniture and curtains had also been purchased. However, some floor areas in the clinical room and office areas remained in need of replacement. Toilet and shower floors were stained and in one area tape had been used as a sealant as the flooring was torn. The new flooring outside the smoking area had cigarette burns in several areas. Patches of paint were required in areas where soap dispensers had been replaced.

Rooms were centrally heated with pipe work and radiators were guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean and hygienic, but was not free from offensive odours, due to the smell of cigarette smoke that was evident in the main corridor, adjacent to two smoking rooms.

Current national infection control guidelines were followed. The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs, and furnished to support resident independence and comfort.

The approved centre was non-compliant with this regulation for the following reasons:

a) **The registered proprietor did not ensure that the premises were maintained in good structural and decorative condition due to marked floors, stained toilet and bathroom floors, torn toilet floor covered in tape, and patches of unpainted walls, 22(1)(a).**
b) **The approved centre was not free from offensive odours as cigarette smoke could be seen and smelt in the main corridor leading to the dining room, 22(1)(a).**
c) **The registered proprietor did not ensure that the environment was maintained with due regard to the safety of residents as ligature points were not minimised, 22(3).**

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

NON-COMPLIANT

Risk Rating MODERATE

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in October 2020, and included the following requirements:

- The process for ordering resident medication.
- The process for prescribing resident medication.
- The process for storing resident medication.
- The process for administration of resident medication, including routes of medication.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. All MPARs contained a record of appropriate medication management processes, including the following: a record of any (or no) allergies or sensitivities to medications; a record of all medications administered to the resident; a clear record of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident. However, the frequency of administration, including the minimum dose interval, for 'as required' (PRN) medication was not recorded in four of the five MPARs inspected.

All entries in the MPARs were legible and contained the signature of the medical practitioner or nurse prescriber for each entry. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file. There was no direction to crush medication in any of the MPAPs inspected.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified and Scheduled 2 and 3 controlled drugs were secured separately from other medications to ensure further security.

The approved centre was non-compliant with this regulation because the frequency of administration for 'as required' PRN medication, including the minimum dose interval, was not stated in five Medication Prescription and Administration Records inspected, 23(1).

Regulation 24: Health and Safety

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in June 2022.

The approved centre was complaint with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in March 2021, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times. A Clinical Nurse Manager 1 (CNM1) was on duty on all shifts and was the nurse in charge. In the event of annual leave or absence of a CNM1, a senior nurse was appointed as the nurse in charge. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. A psychologist, occupational therapist and social worker were employed by the approved centre. Not all healthcare staff were trained in Basic Life Support, Fire Safety, the Management of Violence and Aggression, and the Mental Health Act 2001. See the following table for a breakdown of the numbers and percentages of staff trained in each of the mandatory subjects:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (15)	15	100%	15	100%	15	100%	15	100%
Consultant Psychiatrist (9)	6	67%	5	56%	5	55%	8	89%
Medical (17)	10	59%	13	76%	15	88%	11	65%

Occupational Therapist (7)	7	100%	7	100%	7	100%	7	100%
Social Worker (7)	6	86%	6	86%	7	100%	7	100%
Psychologist (5)	5	100%	5	100%	4	80%	5	100%

The approved centre was non-compliant with this regulation for the following reasons:

a) **The registered proprietor did not ensure that all healthcare staff were trained in Fire Safety, Basic Life Support, and the Management of Violence and Aggression, 26(4).**
b) **The registered proprietor did not ensure that all staff were trained in the Mental Health Act 2001, 26(5).**

Regulation 27: Maintenance of Records

COMPLIANT

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.

(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.

(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.

(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

Note: Actual assessment of food safety, health and safety and fire risk records is outside the scope of this Regulation, which refers only to maintenance of records pertaining to these areas.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in June 2020, and included the following:

- The records required to be created for each resident.
- Those authorised to access and make entries in the residents' records.
- Residents' access to resident records.
- Record retention periods.
- The destruction of records.

Resident records were reflective of the resident's current status and the care and treatment being provided. All residents' records were secure and in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. The records were developed and maintained in a logical sequence and kept in good order with no loose pages.

Throughout the approved centre, records were appropriately secured from loss, destruction, tampering, or unauthorized access. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

(2) The registered proprietor shall ensure that the register includes the information specified in Schedule 1 to these Regulations.

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

INSPECTION FINDINGS

All operating policies and procedures were reviewed within the required three-year time frame, having due regard to any recommendations made by the Inspector or the Commission.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. There had been no tribunal in the approved centre since the last inspection.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in September 2020, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaints procedure, including how to contact the nominated person, was clearly displayed on the wall of the main entrance of the approved centre.

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan (ICP). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented. The registered proprietor ensured that the quality of service, care, and treatment was not adversely affected by reason of the complaint being made.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in July 2022, and included the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for protecting children and vulnerable adults in the care of the approved centre.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. The risk management procedures did not actively reduce identified risks to the lowest practicable level in the approved centre. The need for a call bell system had been added to the risk register in June 2022 and was rated high. At the time of inspection, the call bell system had not been installed. Funding had been approved, but no date had been set for the installation. The risk posed by the internal smoking room was recorded on the risk register but there were no actions evident on the risk register to reduce this risk to the lowest practicable level. On the day of inspection, the internal smoking-room door was open at all times and a plume of smoke was evident in the main communal corridor of the approved centre. This internal smoking area was adjacent to resident bedrooms and on the same corridor as the dining rooms and sitting areas of the approved centre.

Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

Individual risk assessments were completed in conjunction with medication requirements or administration, and resident transfer and discharge. Individual risk assessments were also completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was non-compliant with this regulation for the following reasons:

a) **The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk, as the need for a call bell system was risk-rated as red since June 2022 and was still not installed in the approved centre at the time of inspection, 32(1).**
b) **The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk, as the internal smoking room in the approved centre was recorded on the risk register but no plan was evident to remove this risk to non-smoking residents, 32(1).**

Regulation 33: Insurance

COMPLIANT

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

The registered proprietor shall ensure that the approved centre's current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the approved centre.

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently in the main entrance of the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

9.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: “prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”.

The Mental Health Act, 2001 (“the Act”) does not impose a legal duty on persons working in the mental health services to comply with codes of practice, except where a legal provision from primary legislation, regulations or rules is directly referred to in the code. Best practice however requires that codes of practice be followed to ensure that the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.

Admission, Transfer and Discharge

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to admission, transfer, and discharge. The policy was last reviewed in July 2020, and included all of the policy-related criteria for this code of practice.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policy.

Monitoring: Audits had been completed on the implementation of and adherence to the admission, transfer, and discharge policy.

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family and medical history, current and historic medications, social and housing circumstances, current mental health state, risk assessment, and all other relevant information. A key worker system was in place, full physical examination carried out, and a family member or carer was involved in the admission process with the resident's consent.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse and other risks, and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team (MDT), and family or representative, where appropriate.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare provider within three days. A comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 22: Premises					
Reason ID : 10003753		**The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition due to marked floors, stained toilet and bathroom floors, torn toilet floor covered in tape, and patches of unpainted walls, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	New flooring was approved and installed. New sinks / toilets and painting completed. A Health and Safety audit was completed	Review of premises/ Audit reviews/minor capital meetings / maintenance meetings are held with management of the unit.	Realistic	27/03/2023	Maintenance Dept. Director of Nursing, CNM2s, CNM1 and Assistance Director of Nursing.
Preventative Action	A cleaning schedule is in place and maintenance programme is in place. Monthly meetings with Maintenance Team and Business Managers, are held. Health and Safety audits performed weekly.	Review of premises. Ligature audit Minutes from minor capital meeting reviewed.	Achievable	27/03/2023	Maintenance dept. Director of Nursing, CNM2s, CNM1 and Assistance Director of Nursing
Reason ID : 10003754		**The approved centre was not free from offensive odours as cigarette smoke could be seen and smelt in the main corridor leading to the dining room, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A smoking cessation group has commenced on the unit. Engagement with the resident	Regular audit and community meetings. Review of premises. Feedback from staff and families Evidence	Realistic	30/06/2023	Maintenance Dept.

	takes place on a weekly basis at their community meetings and includes education on smoking cessation and health and wellbeing. The module on smoking cessation within Mental Health Services, which incorporates nicotine reduction therapy, will be followed. A new ventilation system has been approved. A sealed safety door and a smoke sensor has been obtained and is awaiting installation.	of community resident meetings in care plan.			
Preventative Action	Smoking cessation group. Information provided from the HSE Health Promotion department in relation to smoking cessation.	Individual and group work.	Achievable	27/03/2023	CNM1, CNM2, Adon, key nurse. HSE resources
Reason ID : 10003755		**The registered proprietor did not ensure that the environment was maintained with due regard to the safety of residents as ligature points were not minimised, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Minimisation of ligature points ongoing. Updated ligature audit. New anti-ligature wardrobes and toilets and sinks now in place.	Review of ligature audit Review of premises	Achievable Complete	27/03/2023	ADON, CNM2, Head of Maintenance.
Preventative Action	MHS will continue to provide Minor Capital Funding to the unit to address ligature concerns on an ongoing basis.	Monthly meetings. Review of ligature audit.	Achievable	27/03/2023	Business Manager, ADON, CNM2, CNM1.
Reason ID : 10003756		**The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, due to chipped wall paint, damage to walls door frames, toilets and unclean areas such as toilets, sink holes, walls and floors, 22 1(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A cleaning schedule and decorative maintenance is in place. Minor Capital Funding has been provided by the service to complete necessary works. Flooring, sinks and toilets have been installed. Painting has been completed. Door frames have been added to the quality improvement plan.	Audit and Analysis. Daily review of premises. Safety Pause report.	Achievable and Realistic	27/03/2023	Head of Maintenance/ CNM2/ ADON / Business Manager

Preventative Action	A review of premises is completed daily.	Audit and Analysis A record of review of premises is in place. Documentation available.		25/08/2021	
Reason ID : 10003757		**The registered proprietor did not ensure that the environment was maintained with due regard to the safety of residents as ligature points were not minimised. 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Minimisation of ligature points ongoing. Updated ligature audit New anti-ligature wardrobes and toilets and sinks now in place.	Ligature audit	Achievable Complete	27/03/2023	ADON, CNM2, Head of Maintenance.
Preventative Action	Minor Capital Funding has been provided by the service to complete necessary works.	Monthly meetings.	Achievable	30/09/2021	Business Manager, ADON, CNM2, CNM1.

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10003765		**The approved centre was non-compliant with this regulation because the frequency of administration for 'as required' PRN medication, including the minimum dose interval, was not stated in five Medication Prescription and Administration Records inspected, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All MPARs reviewed and updated as per guidelines and as per Regulation 23.	Audit and Analysis	Achieved	27/03/2023	Registered Medical Practitioners on relevant Multidisciplinary Teams.
Preventative Action	Medication Management Training. Discussed at Safety Pause reports. Discussed at multidisciplinary team meetings. Training provided to all staff at regular intervals.	Weekly Audit	Realistic	27/03/2023	Registered Medical Practitioners on multidisciplinary teams, all multidisciplinary team members, Clinical Director, CNM2, and ADON

Regulation 26: Staffing					
Reason ID : 10003766		**The registered proprietor did not ensure that all healthcare staff were trained in Fire Safety, Basic Life Support, and the Management of Violence and Aggression, 26(4)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Up to date training in all required training, is provided. Dates are provided to all MDTs via e-mail. All heads of Disciplines informed of dates and to provide training records for each of their disciplines to the approved centre. Training is nearing 100% in these areas. (See appendix 1 &2)	Training records to be sent to the approved centre.	Training matrix and analysis of training Matrix Monthly returns to the Mental Health Commission	27/03/2023	All trainers to provide dates and availability, all staff responsible in regards to training. All Heads of Disciplines.
Preventative Action	Analysis of Gaps in Training records. Training discussed at staff meetings.	Copy of Certs to be forwarded to approved centre	Realistic	27/03/2023	All Heads of Disciplines.
Reason ID : 10003767		**The registered proprietor did not ensure that all staff were trained in the Mental Health Act 2001, 26(5).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Training widely available on HSELAND and via the Mental Health Act Administrator. Training is nearing	Copy of Certs to be forwarded to approved centre	Realistic	27/03/2023	All Heads of Disciplines.

	100% in this area. (See appendix 1 & 2)				
Preventative Action	Analysis of Gaps in Training records. Training discussed at staff meetings.	Audit and analysis of Training Matrix.	Achievable	27/03/2023	All Heads of Disciplines and all staff.

Regulation 32: Risk Management Procedures					
Reason ID : 10003758		**The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk, as the need for a call bell system was risk-rated as red since June 2022 and was still not installed in the approved centre at the time of inspection, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A Call Bell System and a sensor falls prevention system is now in place. Weekly tests of call bell system takes place and log kept of same.	Feedback from residents, families and staff. Falls and premises analysis. Documentation available.	Achieved Achievable	27/03/2023	CNM2, Maintenance Department, Business Manager. Risk Advisor.
Preventative Action	Schedule of maintenance is in place for the call bell system.	Analysis and audit.	Achievable	27/03/2023	CNM2, Maintenance Department, Business Manager.
Reason ID : 10003759		**The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk, as the internal smoking room in the approved centre was recorded on the risk register but no plan was evident to remove this risk to non-smoking residents, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Risk Register regarding smoking is reviewed regularly. A smoking cessation group has commenced on the unit. A new ventilation system has been approved. A sealed safety door and a smoke sensor has been approved and is awaiting	Management meetings, staff meetings, premises analysis, safety pause reports and audits.	Achieved Realistic	30/06/2023	CNM2, Maintenance Department, Business Manager. Risk Advisor. ADON.

	installation. Information provided from the HSE Health Promotion department in relation to smoking cessation.				
Preventative Action	Smoking cessation support. Safety audit completed regularly. Staff to support all residents. Service User Engagement Lead has developed of a Charter for smoking at Cappahard Lodge. This incorporates the needs of smoking and non-smoking residents. The purpose of this Charter is to reduce the risk of exposure to staff and non-smoking residents to second hand smoke.	Ongoing analysis Smoking charter is on display.	Achievable. Complete	27/03/2023	ADON, Risk Advisor, Business Manager, Head of Maintenance, CNM2.
Reason ID : 10003760		**Individual risk assessments were not completed prior to administration of medication, as one resident was prescribed medication for nine days without a prescription signature, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The MPAR was updated. All staff are trained in medication management. New	Audit	Completed	27/03/2023	CNM2/ ADON/Clinical Director. All multidisciplinary teams

	pharmacy based training provided in March 2023 attended by Cappahard Staff. Regular review and update of MPARs by teams.				and Registered Medical Practitioners.
Preventative Action	Weekly medication audits are now completed. All new staff orientated to the policy on medication management and Regulation 23. Also An Bord Altrainais guidelines on medication management.	Audit Discussed at staff meetings.	Achievable	27/03/2023	CNM2/ADON/Clinical Director.
Reason ID : 10003761		**A risk assessment was not completed on discharge for one resident, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All risk assessments for discharges are documented in the clinical files. The risk assessment for the identified rsdient has been completed.	Discharge Audit	Achieved - Completed	30/04/2021	Relevant RMPs
Preventative Action	New discharge checklist to be introduced. This was approved by the Clare /North Tipperary	Discharge Audit	Achievable	01/09/2021	CNM2/Multidisciplinary teams.

	Management Team on August 26th 2021. All staff to be trained on the Code of Practice for Admission/ Transfer and Discharge.				
Reason ID : 10003762		**A clinical risk was identified but did not follow a process or procedure for follow-up in a timely manner relating to a speech and language therapy referral, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A speech and language review has been completed for each resident and recommendations are outlined for each resident in their clinical file.	Audit	Achievable	27/03/2023	CNM2/ GP/ Speech and Language Therapist, Business Manager.
Preventative Action	A timely referral and systematic review system is in place. All staff are orientated to this and resident needs and risks are discussed each morning at report time and during the safety pause.	Audit and Analysis on Regulation 19.		27/03/2023	CNM2/CNM1/ Key Nurse, GP and Speech and language Therapist, Risk Advisor and Business Manager.
Reason ID : 10003763		**Health and Safety risks were not monitored effectively as a fire exit door did not have the key required to unlock the door if required to do so in an emergency, 32(1). The door to sluice room, which held chemicals and other hazards, was observed to be wedged open, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Key is now in place. Sluice room now shut	Analysis	Achieved - Completed	27/03/2023	CNM2/ Domestic staff.

	at all times with a pass code for entry. All staff aware of keeping doors closed and secure.				
Preventative Action	Daily walkabouts by person in charge of the unit for analysis on premises.	Analysis	Weekly analysis / monthly audits.	27/03/2023	CNM2/CNM1/ Domestic Staff, Domestic Supervisor, Risk Advisor.
Reason ID : 10003764		**The door to sluice room, which held chemicals and other hazards, was observed to be wedged open, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Door locked at all times. Relevant staff who require access have a safety code	Audit, premises walkabout.	Realistic/ Achieved	27/03/2023	Cnm2 and Domestic Supervisor. Risk Advisor.
Preventative Action	All staff informed at staff meetings re safety of door being locked. Code changed at intervals	Discussed at report times/ safety pause, premises walkabout	Achievable/ Ongoing	27/03/2023	All staff in Cappahard

Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

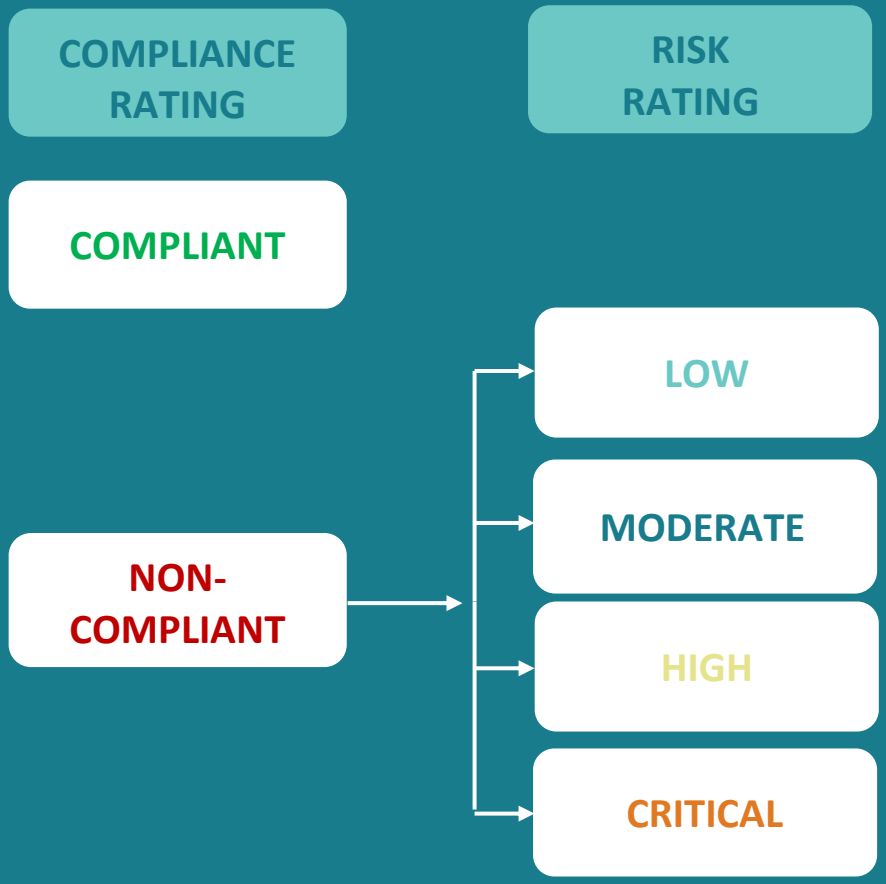
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined, the risk level of the non-compliance will be assessed.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.